

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

12180

## 1. PLACE OF DEATH:

County.....

City or town.....

Mount  
Charles

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or first address where death occurred:

624 W. High St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Owen Raymond Anderson Sr.

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

Ida J. Anderson

7. Birth date of deceased (mo., day, yr.)

Aug. 31 1868

8. (c) If alive, give age..... years

8. AGE:

Years  
78Months  
3Days  
3If less than one day  
hrs. min.

9. Birthplace.....

Kent Co. Maryland

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

FATHER

Albert Anderson

12. Name.....

Caroline Co. Maryland

13. Birthplace

Anna E. Connolly

14. Maiden name.....

Kent Co. Maryland

15. Birthplace

Mary A. Pennington

16. Informant.....

High St. Charles Md.

Address

Burial

Date thereof..... 12/5/46  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Paul

Location

West Fairlee, Kent Co. Md.

18. Funeral director.....

Waring V. Williams

Address

Charles Maryland

19. Date rec'd by registrar

Dec. 5 1946

(Date rec'd by registrar)

Clara S. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Charles-

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

624 High St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Dec. 3

1946, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 20 1946, to Dec 3 1946

end that I last saw him alive on Dec 2 1946.

Immediate cause of death.....

Cancer

DURATION

1 day

Due to the generation of  
cancer cells

1 year

Due to arteriosclerosis

4

Other conditions.....

(Incide pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

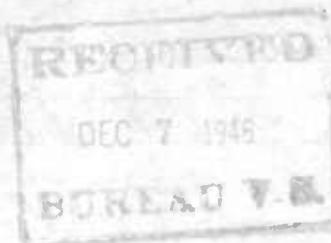
H. G. Simpson

M. D. or other

Address

Cherstern

Date signed 12-4-46



1-35



# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

## Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	2-35	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1063

12188

## CERTIFICATE OF DEATH

Reg. Dist. No. 2000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

## 1. PLACE OF DEATH:

County

City or town

Forest Oliver Hill near Helena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Elizabeth Caulk

4. Sex

Female

5. Color or race

Colored married

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Name of deceased (mo., day, yr.)

Hunting Caulk

July 2, 1896

8. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years      Months      Days      If less than one day

50

0

0      hrs.      min.

9. Birthplace

(Town, county, and state)

Forest Md.

10. Usual occupation

Housewife

11. Industry or business

Name

12. Name

George Brinkley

13. Birthplace

Md.

14. Maiden name

Sarah Collins

Sarah Collins

15. Birthplace

Md.

16. Informant

Address

George Caulk

Forest Hill near Helena

Burial

(Burial, cremation, or removal, which?)

Dec. 9/46

Date thereto

(month) (day) (year)

(month) (day) (year)

(month) (day) (year)

Cemetery or crematory

Location

Oliver Hill near Helena

Oliver Hill near Helena

Funeral director

Address

Edward Bellows

Millington Md.

19. 12-9 1946

(Date rec'd by registrar)

Elizabeth Caulk

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Oliver Hill

City or town

Rural

Address

Forest Hill

Md.

Street No.

1063

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

December 6 1946, at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 PM December 6, 1946, to 6:30 PM Dec 6, 1946

and that I last saw her alive on December 6, 1946.

Immediate cause of death BRONCHIAL ASTHMA

DURATION

6 yrs

Due to

Due to

Other conditions

BRONCHIECTASIS

HYPOTENSION

(Include pregnancy within 3 months of death)

Major findings of operations

NO SURGERY

Date of op.

Autopsy results

NO AUTOPSY

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Shadore J. Paprocki MD

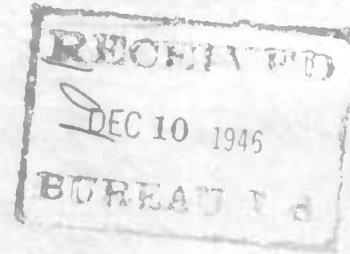
M. D. or other

Address

Forest Hill near Helena

Md. Date signed 12-8-46

Address



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

12189

2020

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Kent  
 County: Chestertown  
 City or town: Chestertown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 48 hours  
 Hospital, institution, or street address where death occurred:  
Kent and Queen Pens  
 How long in hospital or institution? 48 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: Maryland County: Kent  
 City or town: Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Ellanova Christian

## 3. (b) Social Security Number

168-16-3414

4. Sex: Female 5. Color or race: White 6.(a) Single, married, widowed, or divorced: Married  
 6.(b) Name of husband or wife: John P. Christian  
 7. Birth date of deceased (mo., day, yr.): Feb. 19, 1883 1883  
 8. AGE: 63 Years 9 Months 24 Day / If less than one day hrs. min.  
 9. Birthplace: Quaker Neck, Kent Co., Maryland  
 (Town, county, and state)  
 10. Usual occupation: Housewife and cannery worker

11. Industry or business:  
 FATHER: 12. Name: Edward Crew  
 13. Birthplace: England  
 MOTHER: 14. Maiden name: Mary Cannon  
 15. Birthplace: Maryland  
 16. Informant: Mrs. Grace Tibbett  
 Address: Cannon St. Chestertown, Md.

17. Burial: Date thereof: Dec. 15, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory: Chester Cemetery  
 Location: Chestertown, Md.  
 18. Funeral director: J. Willis Wells  
 Address: Chestertown, Md.

19. Date rec'd by registrar: Dec. 14, 1946 Class A. Barnes  
 (Date rec'd by registrar) (Signature)  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13, 1946 at PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 11, 1946 to December 13, 1946  
 and that I last saw her alive on December 13, 1946

Immediate cause of death:

Carcinoma of stomach  
Stomach

Due to: operation

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations: Carcinoma of stomach  
 Date of op.: 12-12-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A.C. Dick

M. D. or other

Address: Chestertown, Md. Date signed: 12-13-46

STATED TO SUBJECT FROM STATE OF ALABAMA

RECEIVED IN THE OFFICE OF THE ATTORNEY GENERAL

RECEIVED

RECEIVED

DEC 17 1946

AM-256-8

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12190

## CERTIFICATE OF DEATH

12190

Reg. Dist. No. 2030

W  
VS ALB  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Rocky Neck*  
 County: *Carroll*  
 City or town: *Rocky Neck*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *Life time*  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

## 3. (a) FULL NAME

*Anna Sarah Albarn*  
 4. Sex: *Female* 5. Color or race: *white* 6. (a) Single, married, widowed, or divorced: *widow*

6. (b) Name of husband or wife: *James Bruce Albarn*  
 deceased

7. Birth date of deceased (mo., day, yr.): *January 17 1879* 6. (c) If alive, give age: *years*

8. AGE: *69* Years *11* Months *4* Days If less than one day: *hrs.* *min.*

9. Birthplace: *Rocky Neck, Rock Hall*  
 (Town, county, and state)

10. Usual occupation: *Housewife*

11. Industry or business

MOTHER FATHER  
 12. Name: *Elizabeth Johnson*  
 13. Birthplace: *Rock Hall*

MOTHER  
 14. Maiden name: *Waller Rock*  
 15. Birthplace: *Rock Hall*

16. Informant: *Mrs. Bertha Johnson*  
 Address: *Rock Hall RR*

17. Burial: *Burial* Date thereof: *Dec 24*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: *Worley Chapel*  
 Location: *Rock Hall Md*

18. Funeral director: *Edgar L. Lane*  
 Address: *Belvoir Hill Md*

19. Dec 21 1946 S. Elwood Bryan  
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State: *Maryland* County: *Carroll*  
 City or town: *Rocky Neck Rock Hall RR*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *December 21 1946* 925

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 1943 to Dec 21 1946* and that I last saw her alive on *December 21 1946*

Immediate cause of death: *Acute myocarditis*

Due to: *Excessive exertion*

Due to: *Malnutrition*

Other conditions: *Arteriosclerosis*

(Include pregnancy within 8 months of death)

Major findings of operations: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: *Franklin Smith*  
 M. D. or other

Address: *Belvoir Hill Md* Date signed: *Dec 21 1946*

RECEIVED

DEC 31 1946

REREAD

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 67

## CERTIFICATE OF DEATH

Reg. Dist. No. 12192020

## 1. PLACE OF DEATH:

Kent

County.....

Chestertown

(If outside city or town limits, write RURAL and give nearest town)

City or town.....

life

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crew Nursing Home

How long in hospital or institution?

## 3. (a) FULL NAME

Miss. Belle Emory

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	single

6. (b) Name of husband or wife.....

none

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 13, 1872

8. AGE:	Years	Months	Days	If less than one day
	74	8	7	hrs. min.

9. Birthplace.....

Kent Co. Maryland

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

12. Name.....

Robert S. Emory

13. Birthplace.....

Queen Anne Co. Maryland

14. Maiden name.....

Julianne Wilkins

15. Birthplace.....

Kent Co. Maryland

16. Informant.....

Crew Nursing Home Records

Address.....

Chestertown, Maryland

Burial.....

Date thereof..... Dec. 24 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Chester Cem.

Location.....

Chestertown, Md.

16. Funeral director.....

J. Willis Wells

Address.....

Chestertown, Md.

19. Dec. 21 1946

(Date rec'd by registrar)

Clara L. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Kent

City or town..... Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 20 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 1946 to Dec. 20 1946

and that I last saw her alive on Dec. 20 1946

Immediate cause of death.....

Influenza &amp; pneumonia

Due to.....

Influenza

Due to.....

Influenza

Other conditions.....

Pellagra

(Include pregnancy within 3 months of death)

Major findings or operations.....

Pellagra

Date of op.....

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

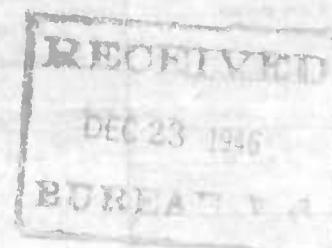
Means of injury.....

Injured at work?.....

23. SIGNATURE.....

John S. Barnes

Date signed..... Dec. 21 1946



1-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

12192

## CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1. PLACE OF DEATH:  
County Kent  
City or town Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life time

Hospital, institution, or street address where death occurred: 349 High St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Kent  
City or town Chesapeake  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 349 High St.  
(If rural, give LOCATION)

## 3. (a) FULL NAME

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

## 3. (b) Social Security Number

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) October 12, 1863 6. (c) If alive, give age..... years

8. AGE: Years 83 Months 1 Days 19 If less than one day

9. Birthplace Chesapeake (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Chesapeake

12. Name Ryan D. Fowler

13. Birthplace Chesapeake (Town)

14. Maiden name H. Adelaide Frazier

15. Birthplace Chesapeake

16. Informant William S. Fowler

Address Chesapeake (City)

17. Burial Burial Date thereof Dec. 3 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cemetery Chesapeake

Location Chesapeake, Maryland

18. Funeral director Wm. V. William

Address Chesapeake, Maryland

19. Dec. 3 1946 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st, 1946 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 2 1946 to January 30 1946

and that I last saw her alive on January 30 1946

Immediate cause of death

Cardiac Nephritis DURATION 11 mo

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank C. Smith M. D. or other

Address Chesapeake, Maryland Date signed Dec. 1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED FEDERAL BUREAU OF INVESTIGATION

1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore <sup>III-A</sup>

12193

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

Chesterfield

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

all day

Hospital, institution, or street address where death occurred:

Court St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Charles Henry Gland

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

col

Married

6. (b) Name of husband or wife.....

Ollie Gland

?

years

7. Birth date of

deceased (mo., day, yr.)

January 10, 1892

8. (c) If alive, give age ? years

8. AGE:

Years

Months

Days

If less than one day

54

11

13

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Chesterfield, Maryland

10. Usual occupation.....

labor

11. Industry or business

Miscellaneous

12. Name.....

Doughers Gland

13. Birthplace

Chesterfield, Maryland

14. Maiden name.....

Laura Jones

15. Birthplace

Chesterfield, Maryland

16. Informant.....

Laura Gland (Mother)

Address

Chesterfield, Maryland

17. Burial

Date thereof..... 12/26/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Chesterfield - Annapolis Neck

Location.....

Home Chesterfield, Maryland

18. Funeral director.....

Waring V. Williams

Address

Chesterfield, Maryland

19. Dec'd. 12/6/46

(Date rec'd by registrar)

Clara S. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chesterfield (If outside city or town limits, write RURAL and give nearest town)

Street No..... 200 Court St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

216-05-6701

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... December 23, 1946, at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-22 1946, to 12-23 1946

and that I last saw h. s. alive on 12-23 1946

Immediate cause of death.....

Pulmonary edema

Due to arterial hypertension

DURATION

3 hours

?

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

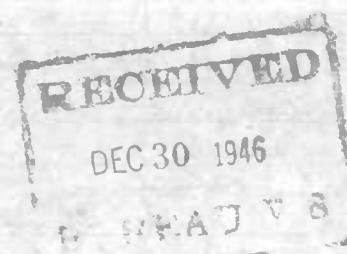
R. Bert W. Davis

M. D.

Address..... Chesterfield, Md. Date signed..... Dec 26, 1946

RECEIVED TO THE UNITED STATES GOVERNMENT

RECEIVED TO THE UNITED STATES GOVERNMENT



1-35

VS A15  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 31

## CERTIFICATE OF DEATH

12194

2030

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... *Keelt*City or town..... *Rock Hall, Rural*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *1 yr. 6 mos.*

Hospital, institution, or street address where death occurred:

*Greys Inn*

How long in hospital or institution?.....

## 3. (a) FULL NAME

*James S. Kauffman*4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *married*6. (b) Name of husband or wife *Theresa Kauffman*7. Birth date of deceased (mo., day, yr.) *April 26 1887*8. AGE: Years *59* Months *7* Days *14* If less than one day  
hrs. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace *Baltimore, Md.*  
(Town, county, and state)10. Usual occupation *retired painter*

## 11. Industry or business

12. Name *Charles S. Kauffman*13. Birthplace *not known*14. Maiden name *Leviller Kauffman*15. Birthplace *Wagers Town, Pa.*16. Informant *from Theresa Kauffman*Address *Rock Hall, Md.*17. (Burial, cremation, or removal: Which?) *Burial* Date thereof *12-12-46*  
(month) (day) (year)Cemetery or crematory *Daniel Ridge*Location *Baltimore, Md.*18. Funeral director *J. Willis Tewels*Address *Westtown, Md.*

19. 12/11/46 Date rec'd by registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Keelt*City or town *Rock Hall, Rural*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Greys Inn*

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

212-07-2428

## MEDICAL CERTIFICATION

2D. DATE OF DEATH *December 10 1946* at *12:40 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *see 9 A.M.* 1946 to *Dec 10* 1946 and that I last saw him alive on *12-9* 1946.

Immediate cause of death

*angina pectoris**Due to chronic myocarditis**Due to Co. of prostate and bladder*

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations *Co. of prostate and bladder* Date of op. *Dec 46*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE *Albert a Burgard* M. D. or otherAddress *Rock Hall, Md.* Date signed *12/10/46*

RECEIVED

DEC 27 1946

BUREAU V. S.

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 49a

12195

## CERTIFICATE OF DEATH

Reg. Dist. No. 2020

## 1. PLACE OF DEATH: Kent

County.....

Chestertown

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

life

How long in above place of death?

Hospital, institution, or street address where death occurred:

Queen St.

How long in hospital or institution?

## 3. (a) FULL NAME

Emma Agnes Knight

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

single

6. (b) Name of husband or wife.....

none

7. Birth date of deceased (mo., day, yr.)

Dec. 2, 1872

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

74

0

25

hrs.

min.

9. Birthplace..... Cecil Co. Maryland

(Town, county, and state)

10. Usual occupation.....

bookkeeper (retired)

11. Industry or business.....

12. Name..... Wm. O'B. Knight

13. Birthplace..... Penna.

14. Maiden name..... Joanne Morgan

15. Birthplace..... Maryland

16. Informant..... Mr. Wm. O'B. Knight

Address..... Chestertown, Md.

17. Burial.....

Date thereof..... Dec. 28, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Chester Cem.

Location.....

Chestertown, Md.

18. Funeral director.....

Address..... J. Willis Wells

Address..... Chestertown, Md.

19. Date rec'd by registrar.....

Dec. 28, 1946

(Date rec'd by registrar)

Clara S. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

no

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

December 25

46

10

55 P.M.

20. DATE OF DEATH..... 11/23/46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on 12/25/46

Immediate cause of death..... Cachexia xxx

19

19

12/25/46

19

Due to..... Abdominal carcinomatosis

6 months

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations which lead to obstruction

peritoneal transplants from carcinomatous ovarian cyst

op. Approx.

Sept 1, '46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

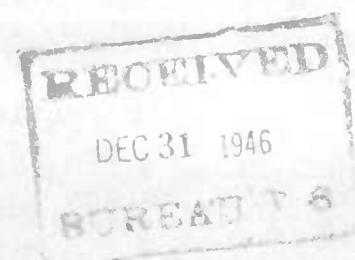
R. W. Barnes

M. D. XXXX

12/26/46

Address.....

Date signed.....



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 31-3

12196

## CERTIFICATE OF DEATH

Reg. Dist. No. 2010

1. PLACE OF DEATH: Kent  
 County.....  
 City or town.....Kentmore Park  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred: Kennedyville P. & L. #

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Kent  
 City or town.....Kentmore Park  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....Kennedyville P. & L.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....Yankee War Veteran

## 3. (a) FULL NAME

Conrad D. dos Kamp

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife.....Claire M. dos Kamp

7. Birth date of deceased (mo., day, yr.) Aug. 23 1877 8.(c) If alive, give age.....68 years

8. AGE: Years 69 Months 4 Days 7 If less than one day  
 hrs. ..... min. ....

9. Birthplace.....Orange Town N.Y. (Colleham)  
 (Town, county, and state)

10. Usual occupation.....retired

11. Industry or business.....

MOTHER FATHER  
 12. Name.....Conrad D. dos Kamp  
 13. Birthplace.....Unknown

MOTHER  
 14. Maiden name.....Elijah Mac Donald  
 15. Birthplace.....Scotland

18. Informant.....Mrs. Claire M. dos Kamp  
 Address.....Kentmore Park, Maryland

17. Burial.....Burial Date thereof.....Jan 3 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Shrubbury  
 Location.....near Kennedyville Maryland

18. Funeral director.....Marie V. Williamson  
 Address.....Chesapeake Mort

19. Date rec'd by registrar.....Jan 2 1947 J. W. Pollock  
 Registrar

3. (b) Social Security Number  
213-22-819

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 30 1946 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1946 to Dec 29 1946  
 and that I last saw him alive on Dec 29 1946

Immediate cause of death.....Myocardial Decompen-  
 sation DURATION 2 DAYS

Due to.....CHRONIC MYOCARDITIS —  
ARTERIOSCLEROTIC HEART DISEASE AND  
HYPERTENSIVE CARDIO VASCULAR  
DISEASE DURATION 5 YRS

Other conditions.....CHRONIC NEPHROSIS WITH  
HYPOTENSION (include pregnancy within 3 months of death) DURATION 2 YRS

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....Theodore F. Paprocki M.D.  
 M. D. or other Galena

Date signed 12-31-46

RECEIVED FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

ST. LOUIS FIELD OFFICE

RECEIVED

JAN 4 1947

BUREAU OF INVESTIGATION

1-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12197

## CERTIFICATE OF DEATH

Reg. Distr. No. 2020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

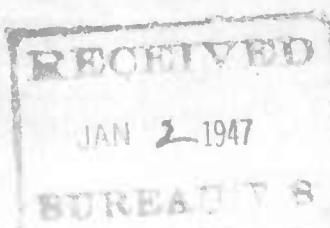
VS A15 9-45-15 M

1. PLACE OF DEATH: Kent  
 County.....  
 City or town..... near - Chestertown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, Institution, or street address where death occurred:.....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County..... Kent  
 City or town..... Chestertown - R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... NO

3. (a) FULL NAME  
 Katherine P. Mc Kee  
 4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced  
 Female white single  
 6.(b) Name of husband or wife..... none  
 7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years  
 Sept. 24, 1864  
 8. AGE: Years Months Days If less than one day  
 82 3 4 hrs. min.  
 9. Birthplace..... Kent Co. Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Housework  
 11. Industry or business  
 12. Name..... Daniel McKee  
 13. Birthplace..... Ireland  
 14. Maiden name..... Hannah Braceland  
 15. Birthplace..... Ireland  
 16. Informant..... Miss. Annie Mc Kee  
 Address Chestertown, Md.  
 17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory..... Chester Cem.  
 Location..... Chestertown, Md.  
 18. Funeral director..... J. Willis Wells  
 Address Chestertown, Maryland  
 19. Dec. 30 1946 Date rec'd by registrar..... Class L. Barnes  
 Registrar

3. (b) Social Security Number none  
 MEDICAL CERTIFICATION  
 20. DATE OF DEATH..... December 28 1946 at 4 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1946 to Dec. 27 1946 and that I last saw her alive on Dec. 27 1946  
 Immediate cause of death..... Cardiac Arrest  
 Due to..... Heart Disease  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... Frank W. Smith  
 M. D. or other.....  
 Address..... Chestertown  
 Date signed..... 12/28/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12198

## CERTIFICATE OF DEATH

Reg. Dist. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

George Lewis Mench

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife.....

Emiley Mench

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Jan 7 1881

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

B Worlton, Md.

(Town, county, and state)

10. Usual occupation.....

Store Keeper

11. Industry or business

own

12. Name.....

Joseph Lewis Mench

13. Birthplace

Worlton, Md.

14. Maiden name.....

Mary Anna Willis

15. Birthplace

Broadmech Rochester

16. Informant.....

Mrs. Emily Mench

Address

Rock Hall, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Wesley Chapel

Location

Rock Hall, Md.

18. Funeral director

Edgar L. Lane

Address

Blanch Hill, Md

19. Dec'd:

(Date rec'd by registrar)

1946 S. Elwood Bongers

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Keset

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Emebieh

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

December 4 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 20 1946 to Dec 4 1946

and that I last saw him alive on Nov 1946

Immediate cause of death

Carcinoma of stomach  
and liver

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

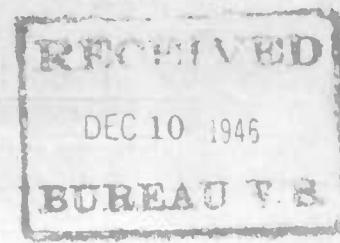
Albert A. Burgard

M. D. or other

Address

Rock Hall, Md.

Date signed



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 910

12191

## CERTIFICATE OF DEATH

Reg. Dist. No. 2021

## 1. PLACE OF DEATH:

County.....

Pent

City or town.....

Prima

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all the

Hospital, institution, or street address where death occurred:

Chesapeake R.R. #3

How long in hospital or institution?

## 3. (a) FULL NAME

Marion S. Parsons

## 4. Sex

M W Widowed

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

## 6.(b) Name of husband or wife

(late) Ella Parsons

## 7. Birth date of deceased (mo., day, yr.)

## 6.(c) If alive, give age..... years

July 27, 1886

## 8. AGE:

Years

Months

Days

## If less than one day

60

1

2

hrs. min.

## 9. Birthplace

Went, Pent Co. Md.

(Town, county, and state)

## 10. Usual occupation

farmer

## 11. Industry or business

farming

## 12. Name

Thomas Parsons

## 13. Birthplace

Pent Co. Maryland

## 14. Maiden name

Ella Parsons

## 15. Birthplace

Pent Co. Maryland

## 16. Informant

M. Walter Parsons

## Address

Chesapeake R.R. #3

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

## Cemetery or crematory

Chesapeake

## Location

Chesapeake, Maryland

## 18. Funeral director

Marion V. Williams

## Address

Chesapeake, Maryland

## 19. Date rec'd by registrar

Dec. 31, 1946

Class L. Barnes

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Pent

City or town..... (W.M.) Pomona (If outside city or town limits, write RURAL and give nearest town)

Street No..... Chesapeake R.R. #3 (If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec. 29, 1946 at 4 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 29, 1946 to Dec. 29, 1946 to Dec. 29, 1946 and that I last saw her alive on Dec. 29, 1946.

## Immediate cause of death

Gastric Hemorrhage DURATION

Gastric Hemorrhage

## Due to

Gastric Hemorrhage

## Due to

Gastric Hemorrhage

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operation

None

Date of op.

## Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Fall from bed

Injured at work?

Fall from bed

## Signature

John H. Williams

M. D. or other

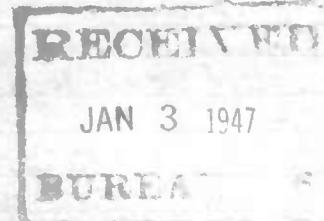
## Address

Chesapeake, Maryland

Date signed

RECEIVED 30 JANUARY 1948 AIR MAIL

STANISLAW STASZEWSKI



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12200

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

## 1. PLACE OF DEATH:

County

Realt-

City or town

Norton and Rural Butlerlawn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Levi Seeneey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored Married

6. (b) Name of husband or wife

Tronice Seeneey

6. (c) If alive, give age 76 years

7. Birth date of

deceased (mo., day, yr.)

Mar 16 1876

8. AGE:

Years

Months

Days

If less than one day

70

10

3

hrs.

min.

9. Birthplace

Butlerlawn Rural Norton and

(Town, county, and state)

10. Usual occupation

Farm work

11. Industry or business

Farm

12. Name

Richard Seeneey

13. Birthplace

Butlerlawn Rural Norton and

14. Maiden name

Henretta Butler

15. Birthplace

Butlerlawn Rural Norton and

16. Informant

Tronice Seeneey

Address

Norton and Rural Butlerlawn

Burial

Date thereof Dec 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mount Adine

Location

Butlerlawn Rural Norton and

18. Funeral director

P. B. Fellows

Address

Still Pond and

19. Dec. 21, 1946

Classard Barnes

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Realt-

City or town

Norton and Rural

Street No.

Milestone

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2d. DATE OF DEATH Dec 19 1946 af 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Realt 1946 to Dec 19 1946

and that I last saw him alive on Dec 14 1946

Immediate cause of death

Chronic Card or Myocarditis

Second diagnosis

DURATION

Due to

Elton Broadbent

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

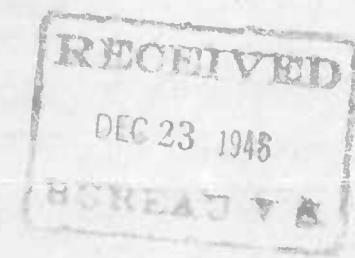
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Oberd Burgard M. D. or other

Address Rock Hall, Md Date signed 11/20/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *92d*

## CERTIFICATE OF DEATH

12201  
Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Kent*  
 County .....  
 City or town ..... *Kent Fairlee*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *45 yrs*  
 Hospital, Institution, or street address where death occurred: *Charlton 11. B. # 2*  
 How long in hospital or institution?

## 3. (a) FULL NAME

*Ida Anne Stoops*

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Married*  
 6. (b) Name of husband or wife *Howard A. Stoops*  
 7. Birth date of deceased (mo., day, yr.) *October 29 1878* 8. (c) If alive, give age *68* years

8. AGE: Years *68* Months *1* Days *23* If less than one day  
 hrs. ..... min. ....

9. Birthplace *Baltimore, Maryland*  
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *None*

12. Name *Samuel Witzel*

13. Birthplace *Balto. Md.*

14. Maiden name *Unknown*

15. Birthplace *Unknown*

16. Informant *Mr. Howard A. Stoops* (husband)

Address *Charlton Bldg 2, Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *12/24/46*  
 (month) (day) (year)

Cemetery or crematory *St. Paul*

Location *Kent Fairlee Kent Co. Md.*

18. Funeral director *Wm. J. Williamson*

Address *Charlton, Maryland*

19. Dec'd by registrar *Dec. 24, 1946* Date rec'd by registrar *Dec. 24, 1946* *Class S. Barnes*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State *Maryland* County *Kent*  
 City or town *Fairlee*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *Charlton Bldg 2*  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *January 22 1946* at *10:00 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 1946* to *Dec 22 1946* and that I last saw her *alive* on *12-22-46*

Immediate cause of death *Chronic Emphysema with*  
*Complications*

Due to *Chronic Arthritis*

Due to *Chronic Arthritis*

Other conditions *—*

(Include pregnancy within 8 months of death)

Major findings of operations *—*

Date of op. *—*

Autopsy results *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *—* Date of *—*

Where did injury occur? *—* (City or town) *—* (County) *—* (State) *—*

Injured at home, farm, industry, public place (where?) *—*

Means of injury *—* Injured at work? *—*

23. SIGNATURE *John Burgeard* M. D. or other *—*

Address *Rock Hall* Date signed *12/28/46*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

12202

## CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1. PLACE OF DEATH:  
County **Kent**

City or town **Chestertown**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **life**

Hospital, institution, or street address where death occurred:

How long in hospital or institution? \_\_\_\_\_

3. (a) FULL NAME  
**Nettie Moody Thompson**

4. Sex <b>female</b>	5. Color or race <b>white</b>	6. (a) Single, married, widowed, or divorced <b>married</b>
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6. (b) Name of husband or wife **Jacob Thompson**  
**living**

6. (c) If alive, give age **years**  
**Aug. 17, 1868**

7. Birth date of deceased (mo. day, yr.) **Aug. 17, 1868**

8. AGE: Years **78** Months **3** Days **22** If less than one day

hrs. **0** min. **0**

9. Birthplace **Kent Co. Maryland**  
(Town, county, and state)

10. Usual occupation **housewife**

11. Industry or business

MOTHER FATHER  
12. Name **James T. Moody**

13. Birthplace **Maryland**

14. Maiden name **Virginia Moody** Hynson

15. Birthplace **Maryland**

16. Informant **Mrs. Merrick Clements**  
Address **Chestertown, Md.**

17. Burial  
(Burial, cremation, or removal. Which?) Date thereof **Dec. 11, 1946**  
**Cemetery or crematory** **Chester Cemetery**

Location **Chestertown, Md.**

18. Funeral director **J. Willis Wells**  
Address **Chestertown, Md.**

19. **Dec. 11, 1946**  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State **Maryland** County **Kent**

City or town **Chestertown**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number  
**no**

## MEDICAL CERTIFICATION

December 9, 1946 19. 9.40 P.M.

20. DATE OF DEATH **November 19, 1946** 19. 10. Dec. 9, 1946 19.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **er** 19. 10. 19. 19.

and that I last saw her alive on **December 9, 1946** 19. 10. 19. 19.

Immediate cause of death **Malnutrition** DURATION

Due to **Anemia**

Due to

Other conditions **Arterio Sclerosis**

(Include pregnancy within 3 months of death)

Major findings of operations **None**

Date of op. \_\_\_\_\_

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **No** Date of \_\_\_\_\_

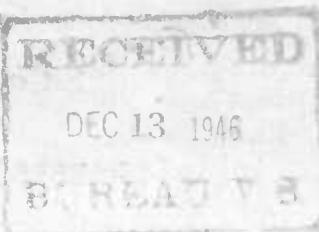
Where did injury occur? **None** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE **Jack Hines** M. D. or other

Address **Chestertown, Md.** Date signed **Dec. 10, 1946**



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